General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Requirements, 38-40 Ninfield Road, Bexhill-on-Sea, East Sussex, TN39 5AB

Pharmacy reference: 9011532

Type of pharmacy: Community

Date of inspection: 28/06/2022

Pharmacy context

This is a community pharmacy in a seaside town. Its main business is dispensing NHS prescriptions. It provides most of its services at a distance, although people can visit the pharmacy to have their prescriptions dispensed or purchase over-the-counter medicines. The pharmacy supplies medication in multi-compartment compliance packs to some people who need help remembering to take their medicines. It has a website but is not currently using it to sell medicines online.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy manages the risks associated with its services. The pharmacy generally keeps the records it needs to, to show that its medicines are supplied safely. People can provide feedback or raise a concern about the pharmacy's services. Team members protect people's personal information properly. And they know how to help protect the welfare of vulnerable people. The pharmacy records any dispensing mistakes, but it does not review the records for patterns or trends. And this could mean that team members are missing out on opportunities to make the pharmacy's services safer.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) and team members had signed the ones relevant to their role to indicate they had read and understood them. The SOPs has been reviewed recently, and the superintendent pharmacist (SI) had obtained new versions and was going through them before implementing them. The need to have one set of clear SOPs, to avoid confusion for team members, was discussed with the SI. And that the SOPs should cover the range of services the pharmacy provided. A team member was able to describe what they could and could not do if the responsible pharmacist (RP) had not turned up in the morning.

Dispensing mistakes that were identified before the medicine was handed to a person (near misses) were recorded in a book. They were not reviewed regularly to identify any patterns or trends, but the SI was planning to do this in the future. Dispensing mistakes where the medicine had been handed to a person (dispensing errors) were recorded on designated forms. The SI gave an example of an error where the wrong strength of bumetanide had been dispensed, and as a result the two strengths had been separated on the shelves. The error had been reported to the pharmacy's indemnity insurer.

The pharmacy had a complaints procedure, and people could make a complaint or provide feedback in person, by phone, or via the pharmacy's website. The SI was not aware of any recent complaints. Prior to the pandemic, the pharmacy had undertaken an annual customer survey, and a new one was planned for 2023.

The pharmacy had current indemnity insurance. It had the right RP notice displayed and the RP records seen had been filled in correctly. Records of emergency supplies were complete. The pharmacy had only dispensed a very small number of private prescriptions and the records did not always state the address of the prescriber. Controlled drug (CD) registers seen had been completed in accordance with requirements and the CD running balances were checked regularly. Random checks of stock for three CDs showed that the quantity in stock matched the recorded balance. Records of unlicensed medicines supplied did not contain the required information, such as who the medicine had been supplied to. This could make it harder for the pharmacy to find out this information if there was a future query.

No confidential information could be seen by people using the pharmacy. There was a data protection and security folder available to staff. Confidential waste was destroyed with a shredder. Staff had individual NHS smartcards, but several had a sticker with a number on it. The stickers were removed during the inspection. The SI confirmed she had done the level 2 safeguarding training and could describe what she would do if she had any concerns. Team members said that they would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for its services, and they do the right training for their roles. They get some ongoing training, and they feel comfortable about raising any concerns.

Inspector's evidence

At the time of the inspection there was the SI (who was also the RP), and two trained dispensers. One of the dispensers finished their shift part-way through the inspection. The pharmacy also employed a driver who had completed the dispenser course. The team was up to date with its workload and there was an organised workflow in the pharmacy.

Team members felt comfortable about raising any concerns. The SI was the regular pharmacist in the pharmacy, and so was easily available. Team members received some ongoing training, such as information from third-party magazines and informal training by the SI on new products or system. But this training was not recorded and not very structured, which could make it harder for team members to keep their knowledge and skills up to date. The Si felt able to take professional decisions to help keep people safe. Team members were not set any targets that they had to meet.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are kept clean, safe, and secure. People can have a conversation with a team member in a private area. The pharmacy could do more to ensure that its website is kept up to date and accurate.

Inspector's evidence

The premises were spacious, and were clean and tidy with suitable lighting throughout. There was a large amount of workspace with sufficient space for dispensing. Cleaning was done once a week and this activity was documented. The premises were secure from unauthorised access. If a person came into the pharmacy, there was a pull-across barrier to help restrict access to the dispensary.

Only a small number of people visited the pharmacy in person, and there was usually only one person at a time in the pharmacy. If someone wanted a conversation with a team member in a private area, there was a small room available. But the room was not very tidy. The SI said that to date nobody had asked to use the room. The pharmacy had a website and had previously sold over-the-counter medicines online, but the SI confirmed that the pharmacy no longer sold medicines online. The website still listed medicines, although they showed up as out of stock when a purchase was attempted. It was discussed with the SI of the need to ensure the website was up to date and accurate.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services in a safe and efficient way. It obtains its medicines from reputable suppliers and generally stores them properly. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People can access the pharmacy's services.

Inspector's evidence

The pharmacy had a small step from the street, and people rang the doorbell to enter. Team members explained that they assisted people who needed additional help. Most people contacted the pharmacy by phone rather than visiting in person. The pharmacy had a signposting procedure and the SI was familiar with the other health services available in the local area.

Dispensed multi-compartment compliance packs were labelled with a description of the medication inside, to help people and their carers identify the medicines. The SI showed how the pharmacy retained the empty boxes from the person's previous supply, to help identify if there were any affected batches if a drug recall was issued. These boxes were disposed of when the new medicines were dispensed. Packs did not always have an audit trail to show who had dispensed the pack. This could make it more difficult for the pharmacy to know this information if a mistake had been made. Patient information leaflets were supplied the first few times when a person started a medicine, but the SI said that some people said they no longer wanted them. As the manufacturers sometimes updated the leaflets, this could mean that people may not always have up-to-date information on how to take their medicines safely. People's GPs usually assessed whether a person needed their medicine in a pack.

The pharmacy did not currently have any people who took higher-risk medicines such as warfarin or methotrexate. The SI said that if they did, she would phone the person after each supply to provide counselling information. The team was aware of the additional guidance about pregnancy prevention to be supplied with people in the at-risk group. The packs of valproate-containing medicines had warning cards attached.

The pharmacy kept an electronic record of medicines delivered to people's homes. The record showed the person's signature, as well as the date, time, and location of delivery. The SI said that she did all deliveries of CDs herself, but only after phoning the person to make sure they were at home. The inspector discussed with the SI about the additional risks involved in supplying these medicines at a distance, and the SI was currently reviewing the SOPs. The SI was signposted to the GPhC guidance about pharmacies supplying their services at a distance.

Medicines were obtained from licensed wholesale dealers, and stored in an orderly manner in the pharmacy. Date checking was done regularly and this activity was recorded. A random check of stock did not find any out-of-date medicines. A couple of boxes of medicines contained mixed batches, and there was a small number of loose strips of tablets on the shelves. Not storing the medicines in their original container could make date checks and acting on drug alerts less effective. Liquids with limited shelf lives when opened were marked with the date of opening. Medicines for destruction were separated from stock and kept in designated bins and sacks. CDs were stored securely. Medicines requiring cold storage were stored in a fridge which was kept within the appropriate temperature

range.

The pharmacy received drug alerts and recalls by email from the MHRA. The emails were printed out, and a record made of the action that had been taken in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

There was a range of calibrated glass measures, with some marked for use with only certain liquids to avoid cross-contamination. Tablet and capsule counting equipment was clean. The shredder appeared to be in working order. The phone was cordless and could be moved to a more private area if needed to help protect people’s personal information.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.